

Notice of Privacy Policies

Patient Name: _____ Patient Phone Number: (_____) _____ - _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

We are required by law to:

- Give you this notice of our legal duties and privacy practices with respect to health information.
- Make sure that health information that identifies you is kept private.
- Follow the terms of the *Notice of Privacy Practices* that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- Appointment reminders
- For payment
- For health care operations
- Health oversight activities
- Law enforcement to avert a serious threat to health and safety
- As required by law
- Public health risks
- Lawsuits and disputes

Complaints: If you believe that your privacy rights have been violated, you may file a complaint with us. *All complaints must be in writing.*

Acknowledgement of receipt of this notice: We request that you sign this form acknowledging it will become part of your medical record.

Patient Signature: _____ Date: ____/____/____

Authorization to release protected Health information to third parties:

By signing this authorization, I authorize Palouse Surgeons to release certain protected health information about me to or for the party or patients listed below.

<p><u>I <input type="checkbox"/> Authorize/ <input type="checkbox"/> Request:</u></p> <p>Palouse Surgeons, LLC 825 SE Bishop Blvd Ste 130 Pullman 2301 West A Street, Suite A Moscow P: (509)332-0632 • (208)882-1700</p>	<p>To release my records to:</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____ State: ____ Zip: _____</p> <p>Phone: (____) _____ - _____ Fax: (____) _____ - _____</p>
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Signature: _____ Date: ____/____/____

Patient, Parent, or Legally Authorized Individual

Relationship to the Patient: _____ Phone Number: (_____) _____

Financial Policy

Patient Financial Class Policies:

You are required to present a valid insurance at every visit as needed throughout your care.

Commercial Insurance Carriers:

Palouse Surgeons will bill most insurance carriers for you, if proper paperwork is provided. Any outstanding balances, deductibles and co-payments are due prior to checking in for your appointment. Since your agreement with your insurance carrier is private we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you.

Medicare:

Our office is a Medicare participations provider and we will bill Medicare for you. We will also bill your secondary insurance, if that information is provided to us. Any outstanding balances and deductibles are due prior to your appointment. Any co-insurance and non-covered service will be due as service is rendered.

Workers Compensation:

If your visit is work-related, we will need the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company.

Methods of payment:

Our office accepts the following payment methods: Cash, personal check, credit cards and Care Credit financing options for those patients that qualify.

For returned checks, we assess a **\$35.00** NSF charge and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office.

Accounts not paid according to the terms set above; by signing below you consent that our office reports to an outside collection agency and in the event that your account is turned over for collections you agree to pay all additional fees assessed in the collection for the debt. These fees include collection agency fees and attorney fees.

I agree to pay in full for all services rendered at the time of service.

PRINT NAME

D.O.B

SIGNATURE of patient or person acting on patient's behalf

DATE

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company. Your insurance company will keep your health information confidential.

PLEASE PRINT

PATIENT INFORMATION

Name: _____

Mailing Address _____

City: _____ State: _____ ZIP: _____

SS#: _____ Phone: Home: _____

Cell: _____

Birthdate: _____ Age: _____ Sex: M F Marital Status: _____

If patient is a minor, parent/guardian name: _____

Employer: _____ Occupation: _____

Employer's Address: _____ City: _____

State: _____ ZIP: _____ Work phone: _____

Spouse: _____ SS# _____ DOB: _____

Employer: _____ Work phone: _____

Employer's Address: _____

Who to Contact in Case of Emergency: _____

Address: _____ Phone: _____

Relationship: _____

Family Doctor: _____ Referring Doctor: _____

Insurance Card: (Both sides)

Authorization:

I hereby authorize Palouse Surgeons, LLC or its designated billing agent to furnish information to insurance carriers concerning this illness/accident, and I hereby assign to the doctor all payments for medical services rendered.

I understand that I am financially responsible for all charges, whether or not covered by insurance.

Patient/Parent Signature: _____ Date: _____

Current Medical History

Patient name _____
Date of birth _____
Referred by _____
Major concern _____ Other concerns _____
How long ago did this concern begin? (Be specific) _____
Have you had this diagnosed? ____ If so, what was the diagnosis? _____
What treatment have you tried? _____

Review of Systems

Please circle any symptoms that are bothersome to you now

General

Poor appetite Bleeding/bruise easily Poor balance Fevers
Poor sleeping Weight loss Weight gain Chills
Fatigue Strong thirst Night Sweats Other

Skin & Hair

Rashes Loss of hair Recent moles Ulcerations Itching Other

Head, Eyes, Ears Nose & Throat

Dizziness Concussions Jaw clicks Teeth problems
Eye pain Recurrent sore throats Ringing in ears Cataracts
Sinus problems Nose bleeds Spots in front of eyes Trouble with night vision
Grinding teeth Facial pain Hearing aids
Glasses Earaches Other _____

Cardiovascular

High blood pressure Varicose veins Chest pains Irregular heartbeat
Low blood pressure Fainting Cold hands and feet
Swelling feet Swelling hands Blood clots Difficulty breathing

Respiratory

Cough Coughing blood Difficulty breathing when lying down
Asthma Bronchitis Pneumonia Pain with deep breath

Gastrointestinal

Nausea Abdominal pain/cramps Indigestion Hemorrhoids
Constipation Vomiting Diarrhea Rectal pain

Genitourinary

Pain on urination Frequent urination Blood in urine Urgency to urinate
Kidney stone Sores on genitals Impotency Sexual-transmitted disease

Musculoskeletal

Neck pain Foot/ankle pain Muscle weakness Knee pain Hip pain
Back pain Muscle pain Hand/wrist pain Shoulder pain Other

Neuropsychological

Seizures Loss of balance Poor memory Depression Anxiety

Past Medical/Family History

Patients name _____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart disease						
High blood pressure						
Stroke						
Cancer						
Diabetes						
Asthma/allergies						
Epilepsy/convulsions						
Bleeding disorder						
Kidney disease						
Thyroid disease						
Osteoporosis						
Alcohol/drugs/mental illness						

Your Past Medical History (Please check problems you have had)

<input type="checkbox"/>	Headache	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Prostate disease	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	Gallbladder disease	<input type="checkbox"/>	Measles
<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	Rubella
<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Sexual/menstrual problem	<input type="checkbox"/>	Polio
<input type="checkbox"/>	Dizziness/fainting	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	Diphtheria
<input type="checkbox"/>	Peripheral vascular disease	<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>	Tetanus
<input type="checkbox"/>	Allergies/hay fever	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Dental problems
<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Additional problems
<input type="checkbox"/>	GI disorder	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	Bowel irregularity

Hospitalizations _____

Surgeries _____

Anesthesia _____

Current Medications _____

Allergies _____

